

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 0 — 0 0 5

2. STATE:

Rhode Island3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

July 1, 2000TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN**Technical Correction**☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1923 of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ 12,463,870b. FFY 2001 \$ 12,815,877

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1 to Attachment 4-19A, Page 49. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):**Supplement 1 to Attachment 4-19A, Page 4**

10. SUBJECT OF AMENDMENT:

Disproportionate Share Hospital Policy

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:**See Attached Letter**

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Christine C. Ferguson

14. TITLE:

Director

15. DATE SUBMITTED:

9/14/00

16. RETURN TO:

**Dorothy Karolyshyn
Department of Human Services
600 New London Avenue
Cranston, RI 02920****FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

9/15/00

18. DATE APPROVED:

9/25/00**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

7-1-00

20. SIGNATURE OF REGIONAL OFFICIAL:

ARMA, DMSO

21. TYPED NAME:

22. TITLE:

23. REMARKS:

OFFICIAL

- F. Uncompensated care is defined as the sum of the cost of incurred for inpatient or outpatient services attributable to: 100% of charity care (free care and bad debts per audited financial statements) for which the patient has no health insurance or other third party coverage, less payment received directly from patients; and, costs attributable to Medicaid clients less Medicaid reimbursement.

The utilization rates, costs, and uncompensated care for the most recently completed hospital fiscal year for which data is available (hospital fiscal year 1995) will be utilized to determine each hospital's payment. 1995 uncompensated care costs shall be indexed by the Maxicap for each subsequent year to calculate the costs for the year in which payments are made. The total payment will not exceed the state cap, sec. 1923(g).

- G. Rhode Island's share of any national disproportionate share allocation in addition to the foregoing amounts and any undistributed monies from sections A, C and D (should no hospitals qualify in those categories) shall be added to the \$12,542,615 in section B and distributed by the same proportion and methodology.

TN No. 00-005
Supersedes
TN No. 98-008

Approval Date 9/25/00 Effective Date 7/1/00

OFFICIAL